College of Pharmacists of British Columbia

APPLICATION FOR PHARMACY CLOSURE

Form 4

1. INFORMATION OF CLOSING PHARMACY

Operating Name		**Store #/Identifier (if applicable)**	**Pharmacy Licence Number**	
Pharmacy Address		**City**	**Province** BC	**Postal Code**
Email Address	**Phone Number**	**Fax Number**	**Closing Date** MMM | DD | YYYY	

PHARMACY MANAGER

Manager Name	**Manager's Registration Number**

☐ I have read and understand my duties and responsibilities for closing my pharmacy described in section 18(2)(t) of the *PODSA* Bylaws.

Signature of Pharmacy Manager	**Sign Date** MMM | DD | YYYY

DIRECT OWNER

Name of Authorized Representative	**Position/Title of Authorized Representative**

☐ I have read and understand my duties and responsibilities for closing my pharmacy described in section 18(8)(d) of the *PODSA* Bylaws.

Signature of Authorized Representative	**Sign Date** MMM | DD | YYYY

2. INFORMATION OF RECEIVING PHARMACY*

Operating Name	**Store #/Identifier (if applicable)**	**Pharmacy Licence Number**	
Pharmacy Address	**City**	**Province** BC	**Postal Code**
Phone Number	**Manager Name**		

Items that will be transferred to the receiving pharmacy

- ☐ Prescription drugs (including controlled drug substances)
- ☐ Non-prescription drugs (including exempted codeine products)
- ☐ Medical devices
- ☐ Patient medication records and prescription records

*If more than one receiving pharmacy is involved, complete a separate form for each receiving pharmacy to indicate the items that will be transferred to the receiving pharmacy.

The receiving pharmacy must complete the section below and submit the form to the College within 2 weeks upon receipt of the items:

3. CONFIRMATION OF RECEIPT OF ITEMS FROM A CLOSING PHARMACY

☐ I have received all the items checked above on (received date): _____.

☐ I have faxed a copy of the inventory of narcotics, controlled drugs, targeted substances and benzodiazepines received to the College.

Manager Name	**Manager's Registration Number**
Signature of Manager from the Receiving Pharmacy	**Date** MMM | DD | YYYY